2___ Annual Ethics Training*

I, _____ DHHS/IHS

(Name) Organization

attended the 2___ Annual Ethics Training

_____ _____ _____

(Date) (Location) (Time)

_____

(Employee Signature)

Upon completion, send this certification to:

_____

Area Ethics Contact

_____

(Insert office address)

*This form will be retained on file in the deputy ethics counselor's office/PIES. Form is filled by location (i.e. HQ, Tucson, Billings) and is not subject to the Privacy Act.